Los Angeles Unified School District
Benefits Administration

2023 HEALTH BENEFITS ENROLLMENT FORM – HALF-TIME ACTIVE EMPLOYEES

Employee Number	Last Name	First Name	MI	Phone Number

Address	City	State	Zip Code	Social Security Number

Email Address	☐ Classified ☐ Certificated	*Do Not Write In Shaded Boxes*	**Eff. Date**	**Process Date**	**Initials**

HEALTH PLANS (Select one plan from each category)

MEDICAL PLANS & EMPLOYEE COST PER MONTH			DENTAL PLANS & EMPLOYEE COST PER MONTH		
☐ Anthem Blue Cross Select HMO	-	$642.85	☐ Aetna Dental PPO	-	$40.03
☐ Anthem Blue Cross EPO	-	$844.88	☐ DeltaCare® DHMO	-	$14.02
☐ Health Net HMO	-	$851.52	☐ Western Dental DHMO	-	$10.87
☐ Kaiser Permanente HMO	-	$617.14	☐ No Dental Coverage	-	No Cost
☐ Medical Opt-Out/Cash-Back	-	No Cost			

VISION PLANS & EMPLOYEE COST PER MONTH

☐ EyeMed Vision Care - $3.89	☐ VSP - $3.62	☐ No Vision Coverage - No Cost

DEPENDENT INFORMATION (Attach additional pages if necessary)

Social Security Number	Last Name	First Name	MI	Relationship	Date of Birth	Eff. Date
☐ Male ☐ Female ☐ Non-Binary						
☐ Male ☐ Female ☐ Non-Binary						
☐ Male ☐ Female ☐ Non-Binary						

NOTE: Coverage for eligible employees will be effective the first day of the following month in which the form is received. Eligible dependents will be covered the first day of the following month in which the documentation to verify the dependent status is received. Refer to next page to determine documents needed. Social Security number is mandatory for all dependents. For newborns, Social Security numbers are required within two (2) months of birth.

Is your spouse/Domestic Partner a LAUSD employee? ☐Yes ☐No Employee #_____

THIS FORM WILL NOT BE PROCESSED UNLESS SIGNED AND DATED

I understand this election will remain in effect as long as I remain eligible, or until I make another election during an annual open enrollment period. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and those eligible members of my family listed above for participation in the plans elected. I understand that I am responsible for notifying the District of any change in the eligibility of my dependents and am responsible for premiums and claims incurred on behalf of ineligible dependents. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration. I certify under penalty of perjury that the above information is true and is accurate to the best of my knowledge and belief.

Internal Use

Applicant's Signature		Date:

Instructions

In order to assist the District in ensuring that your eligible dependents are properly enrolled under your District-sponsored plan, please read and follow the instructions below.

- **Complete this form, being sure to list all dependents you wish to have added. If necessary, attach additional sheet(s) of paper to this form.**
  a. List birthdays and Social Security numbers for all dependents. Social Security numbers are mandatory. Social Security numbers for newborns must be provided within two (2) months.
  b. If your spouse/domestic partner is also a District employee/retiree, please list his or her employee number.

- **Provide verification of dependent status for dependents as follows:**
  a. **Spouse** – attach a copy of your registered marriage certificate issued by the state. For new spouses, if a registered marriage certificate is received within 45 days of the marriage date, spouse will be covered effective the date of the marriage.
  b. **Domestic Partner** – submit a notarized Declaration of Domestic Partnership form (available on lausd.org/benefits/forms) and submit the required documentation as outlined in Section II of the Declaration of Domestic Partnership form. If you and your Domestic Partner are registered with the State, in lieu of the documentation outlined in Section II, submit a copy of the certificate issued by the State. If all the required documentation is received by Benefits Administration, coverage will be effective the first of the following month.
  c. **Natural children** – for each child, attach a copy of the official birth certificate. For newborns, if verification of birth is received within 30 days of birth, the child will be covered back to date of birth (complimentary hospital birth certificate is acceptable). If verification is submitted more than 30 days, but less than 5 months, the child will be covered on the first of the following month after the verification is received. After a child is 5 months, an official birth certificate is required.
  d. **Stepchildren** – for each child, attach a copy of the birth certificate, a copy of your registered marriage certificate (issued by the state), and a copy of your latest income tax return showing the child's dependent status.
  e. **Guardianship or adopted children** – for each child, attach a copy of the document verifying legal guardianship or adoption. If you submit legal documentation within 30 days of the guardianship or adoption, coverage will begin on the day of the guardianship or adoption. If submitted after 30 days, coverage will begin on the first of the following month after the legal documentation is received.
  f. **Disabled dependent** – must meet the disability standards of the plan and must be enrolled prior to age 26.

DEPENDENTS FOR WHOM THE REQUIRED DOCUMENTATION IS NOT RECEIVED WILL NOT BE COVERED UNDER YOUR MEDICAL, DENTAL AND/OR VISION PLAN(S) UNTIL THE APPROPRIATE DOCUMENTATION IS RECEIVED.

EFFECTIVE DATE OF ADDITIONS:
Coverage will begin on the first day of the month following the receipt of the Health Benefits Enrollment form along with the required verification. **Example:** If verification and Health Benefits Enrollment form is received by Benefits Administration on January 1st, the dependent's enrollment becomes effective February 1st.

Visit lausd.org/benefits for the Optional Life Insurance Brochure for payroll deducted supplemental life insurance.

TERMINATION OF COVERAGE:
Coverage will be terminated on the last day of the month in which the employee or the dependents became ineligible.

Complete and return this form along with copies of the required documents via fax, email, or mail:

Fax: (213) 241-4247

Email: benefits@lausd.net

Los Angeles Unified School District - Benefits Administration
P.O. Box 513307
Los Angeles, CA 90051-1307

Phone: (213) 241-4262
Website: lausd.org/benefits